OCT 1 1982

Y 1.1/8:97-857

97TH CONGRESS
2d Session

HOUSE OF REPRESENTATIVES

REPORT
No. 97-857

DETERMINATION OF SPACE TO BE PROGRAMED IN MEDICAL FACILITIES OF THE ARMED FORCES FOR MILITARY RETIREES AND THEIR DEPENDENTS

SEPTEMBER 23, 1982.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. NICHOLS, from the Committee on Armed Services, submitted the following

REPORT

[To accompany H.R. 3278]

16

[Including cost estimate of the Congressional Budget Office]

The Committee on Armed Services, to whom was referred the bill (H.R. 3278) to amend title 10, United States Code, to provide additional standards for determining the amount of space to be programed for military retirees and their dependents in medical facilities of the uniformed services, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

Strike out all after the enacting clause and insert the following:

That section 1087 of title 10, United States Code, relating to the programing of space for care of retired members and their dependents, is amended—

(1) by inserting "(a)" before "Space for"; and

(2) by striking out the second sentence and inserting in lieu thereof the following: "The maximum amount of space that may be so programed fora facility is the greater of—

"(1) the amount of space that would be so programed for the facility in order to meet the requirements to be placed on the facility for support of the teaching and training of health-care professionals; and

"(2) the amount of space that would be so programed for the facility based upon the most cost-effective provision of inpatient and outpatient care to persons covered by sections 1074(b) and 1076(b) of this title.

"(b)(1) In making determinations for the purposes of clauses (1) and (2) of subsection (a), the Secretary concerned shall take into consideration—

"(A) the amount of space that would be so programed for the facility based upon projected inpatient and outpatient workloads at the facility for persons covered by sections 1074(b) and 1076(b) of this title; and

"(B) the anticipated capability of the medical and dental staff of the facility, determined in accordance with regulations prescribed by the Secretary of Defense and based upon realistic projections of the number of physicians and

89-606 O

BEST DOCUMENT AVAILABLE

other health-care providers that it can reasonably be expected will be assigned to or will otherwise be available to the facility.

"(2) In addition, a determination made for the purpose of clause (2) of subsection (a) shall be made in accordance with an economic analysis (including a life-cycle cost analysis) of the facility and consideration of all reasonable and available medical care treatment alternatives (including treatment provided under a contract under section 1086 of this title or under part A of title XVIII of the Social Security Act).

"(c) The hospitals at the United States Military Academy, the United States Naval Academy, and the United States Air Force Academy shall have space for inpatient and outpatient care for persons covered by sections 1074(b) and 1076(b) of this title. The amount of such space shall be programed in accordance with subsection (a).".

SEC. 2. (a) Chapter 55 of title 10, United States Code, is amended by adding at the end thereof the following new section:

"**§ 1091. Hospitals at service academies**

"Subject to the availability of appropriations, there shall be a hospital at the United States Military Academy, the United States Naval Academy, and the United States Air Force Academy.".

(b) The table of sections at the beginning of such chapter is amended by adding at the end thereof the following new item:

"1091. Hospitals at service academies.".

SEC. 3. The amendment made by paragraph (2) of the first section of this Act shall apply only with respect to a facility for which funds for construction (or a major alteration) are first appropriated for a fiscal year after fiscal year 1983.

EXPLANATION OF COMMITTEE AMENDMENT

The amendment, which strikes out all after the enacting clause, is a substitute for the bill as introduced. The amendment makes technical changes in the language of the bill.

PURPOSE

The purpose of H.R. 3278 is twofold. First, the bill would provide additional criteria that may be used in determining the amount of space to be programmed for military retirees and their dependents in military medical facilities.

Second, it would state that, subject to the availability of appropriations, there should be a hospital at each of the three military academies.

SUMMARY OF PROVISIONS IN THE BILL

Sizing criteria

Under current law and policy, the size of military medical facilities is based on the workload for active duty personnel and their dependents. Section 1087 of title 10, United States Code, provides that any space in military medical facilities programmed for retirees and their dependents will be limited to that required to meet teaching and training requirements.

The bill would provide an additional criterion for the incremental sizing for retirees and their dependents: space so programmed would be based on the most cost-effective provision of inpatient and outpatient care for retirees. The determination of cost-effectiveness would be based on an economic analysis, including a life-cycle cost comparison of various alternatives for the activity. Thus, the cost of providing medical care to the current beneficiary population under both CHAMPUS (Civilian Health and Medical Program of

BEST DOCUMENT AVAILABLE

the Uniformed Services) and Medicare [1] would be weighed against the capital outlays and other expenditures necessary to construct and operate a military medical facility large enough to provide such care in-house. The committee anticipates that the analysis conducted would review a number of options ranging from total in-house care to the recapture of varying portions of the current CHAMPUS and Medicare workloads.

The decision reached on the appropriate sizing level would be based upon the workload of the facility and would be constrained by the projected availability of medical and dental staff for that facility.

Military academies

The bill would provide, subject to the availability of appropriations, for the operation of a hospital at the U.S. Military Academy, the U.S. Naval Academy, and the U.S. Air Force Academy.

Further, space at the service academy hospitals could be programmed based on the expanded sizing criteria embodied in the bill.

Effective date

The bill would apply to construction projects for which the first funds would be appropriated in fiscal year 1984 or later.

Background and Discussion

By current statute and policy, the amount of space to be included in military medical facilities is limited to that needed for active duty members and their dependents, plus any additional space the service Secretaries determine necessary to meet teaching and training requirements. The increase in sizing provided for teaching and training requirements is the only additional space that may be programmed for military retirees and their dependents, unless there is a critical shortage of community medical facilities in an area with a large concentration of retirees. Included as a part of Public Law 89-614, the Military Medical Benefits Amendments of 1966, the teaching and training requirements criterion has not been amended since that time.

The implementing regulations issued by the Department of Defense in 1968, provide that the services may add an additional 5 percent in non-teaching hospitals or 10 percent in teaching hospitals to the space otherwise planned in order to provide health care for retirees and their dependents. This Department of Defense directive has remained basically unchanged since its issuance despite criticism from both the Congress and the General Accounting Office.

By contrast, the character of the military health care delivery system and the composition of the eligible beneficiary population have changed during the intervening years. Reflecting a similar trend in the civilian sector, an increasing degree of military medical care is provided on an outpatient, rather than an inpatient,

[1] CHAMPUS eligibility terminates when an individual becomes entitled to medicare coverage at age 65 or through disability.

BEST DOCUMENT AVAILABLE

basis. Hospitals built several decades ago were designed principally to support lengthy hospital stays. Newer facilities are instead configured for a variety of outpatient work stations and ancillary support services. Thus, to conform to modern medical practice, a growing number of older facilities must be replaced. Under the existing sizing criteria, many of these replacement facilities will be smaller, in some cases considerably smaller, than the older hospitals they will replace.

How does this compare to the beneficiary population to be served? The size of the active duty force has declined significantly as a result of the reductions in manning made in the wake of the termination of hostilities in Vietnam. At the same time, the retiree population has increased and today represents a growing component of the military medical care system beneficiary population. For example, two decades ago, over 80 percent of the beneficiaries of Air Force health care were active duty personnel and their dependents. Today, approximately 50 percent of all beneficiaries living within Air Force military treatment facility catchment areas are retired members, their dependents and survivors.

There is often neither sufficient space nor adequate staff in many military medical facilities to provide care to all of those eligible. First priority is given to active duty personnel and then, on a space available basis in declining order of priority, to active duty dependents, retirees, their dependents, and survivors. Dependents, retirees, and survivors unable to obtain care in uniformed services facilities are entitled to use CHAMPUS, the Civilian Health and Medical Program of the Uniformed Services. Established in 1966 by Public Law 89-614, the Civilian Health and Medical Program of the Uniformed Services pays hospital and doctor bills for care in the civilian community on a cost-shared basis. Active duty dependents receive greater reimbursement of medical expenses than retirees and their dependents.

With the escalation of costs within the medical sector of the economy over the past decade, the budget for CHAMPUS has increased significantly in recent years and will in fiscal year 1982 be slightly in excess of $1 billion. That compares to just over $500 million during the mid and late 1970's.

In current practice, these burgeoning CHAMPUS costs are not weighed in the decision-making process on the size of a military medical facility to be constructed. In fact, when a substantially older facility is replaced, there is often a decrease in the number of available beds.

The Air Force Regional Hospital at MacDill Air Force Base, Florida, is a good example of the dilemma besetting service health care planners. Under study as a future military construction project, the MacDill hospital presently has 75 operating beds. A new facility, following current Department of Defense regulations, would be restricted to 48 beds, a decline of approximately one-third. Ironically MacDill Air Force Base is located in the fast-growing Tampa, Florida, area, an increasingly popular haven for retirees from around the nation. With a total Department of Defense beneficiary population eligible for military health care within that area projected to be 120,000 by fiscal year 1989, a 48-bed facility will be able to meet only a small portion of requirement for care. The remain-

der will be absorbed by the increasingly costly CHAMPUS program.

This anomaly has not escaped notice. In July 1976 the House and Senate Committees on Appropriations, in their conference report on the military construction appropriations bill for fiscal year 1977, gave the Department of Defense policy guidance concerning several issues related to hospital sizing. The report directed the department to review its planning guidelines for providing beds in military hospitals for retirees, their dependents, and survivors. The report further indicated that Congress would consider providing beds in new military hospitals for beneficiaries now receiving care under CHAMPUS provided that the overall cost of such in-house treatment was less costly to the government.

Despite the congressional guidance, the Department of Defense, as previously noted, has not modified its regulations on sizing military hospitals. A new draft regulation still under review contains criteria similar to the original 1968 instruction with respect to the allocation of space for retirees.

GENERAL ACCOUNTING OFFICE REVIEW

At the request of the Chairman of the Appropriations Committee of the House of Representatives, the General Accounting Office reviewed the hospital sizing methodology used by the Department of Defense. A General Accounting Office report, issued in December 1980 criticized the Defense Department's sizing policies and indicated that the services do not apply the same criteria to both inpatient and outpatient facilities. GAO suggested that the law be modified to provide additional criteria in sizing military medical facilities so that other factors such as the life-cycle cost of the facility could be considered in making a final determination of size. This bill is the result of committee review and refinement of the GAO recommendations.

The General Accounting Office examined several recent studies prepared by private consulting firms that compare the cost of medical care in military hospitals and clinics with the cost in civilian facilities. The studies, one for the San Diego Naval Hospital and the other for the Fort Carson Army Hospital, compared the life-cycle costs of several options for providing care to military beneficiaries in each hospital's area. Life-cycle costs for a project alternative are derived by determining the costs of construction, operation, and other expenses incurred by the Federal government each year over an assumed 20-year time period and discounting the costs using a 10-percent interest rate to arrive at present value costs.

GAO further reviewed a sensitivity analysis conducted by the consulting firm for the San Diego Naval Hospital. This sensitivity analysis verified that the comparative cost results would not change significantly with reasonable variations in the factors and assumptions used in the study, such as the 20-year economic life, the rate of escalation of health care costs, personnel or CHAMPUS costs, project construction or capital costs, and the discount rate.

The General Accounting Office report indicates general agreement with the approach and methodology used by the consultant. GAO further discussed the San Diego and Fort Carson studies with

cognizant health care planners within the Department of Defense and the services and found that they concurred with the overall conclusion of the studies, namely, that medical care provided by the two military hospitals analyzed would be considerably less costly to the Federal government than care by local civilian providers. These findings are consistent with past studies conducted by the Department of Defense and the services.

The General Accounting Office report concluded, in summary, that "these two studies indicate that treating DOD beneficiaries in the military hospitals and clinics can, in some cases, be more cost effective to the government than paying for their care in civilian facilities. They also supply strong evidence that DOD can save money in the long run by adopting a new policy to size hospitals to treat all beneficiaries when proper economic analysis shows this to be most cost effective."

STAFFING CONSTRAINTS

A determination of the capability of the military services to staff a military medical facility must be an integral part of the decision-making process on the most cost-effective size for that facility. With the expiration of the doctor draft at the end of the Vietnam war, the services encountered serious difficulty in attracting and retaining sufficient health care professionals to staff existing medical facilities and to provide care to the current beneficiary population. Congress has subsequently taken several actions that have reversed the decline in the number of military physicians, principally the improvement of the Armed Forces Health Professions Scholarship Program, the establishment of the Uniformed Services University of the Health Sciences, and the enactment of the Uniformed Services Health Professionals Special Pay Act of 1980. As a result, the services are currently able to attract a sufficient number of general practitioners, but shortages of those specialists who can command high salaries in private practice will persist for some period of time.

In view of the shortfalls experienced in the very recent past, the ability of the services to provide sufficient physicians and other medical staff must be a principal determinant in the ultimate sizing of a military medical facility. The General Accounting Office report recommends that projected staffing act as a major constraint on sizing decisions. The committee concurs and has incorporated this recommendation in the bill.

The committee expects that staffing estimates will be based on a realistic time frame, such as the 5-year projections included in current planning documents, the Program Objective Memorandum (POM). In response to committee questioning, both Department of Defense and service officials have indicated that 5-year projections can be made with a substantial degree of accuracy. For example, the majority of future military physician accessions are already in the pipeline through participation in the Armed Forces Health Professions Scholarships Program and through attendance at the Uniformed Services University of the Health Sciences.

The committee further expects that regulations promulgated by the Secretary of Defense relative to sizing projections will be prepared in consultation with the individual services Secretaries.

ECONOMIC ANALYSIS

All of the various legislative proposals previously submitted, including the General Accounting Office's recommendations, had based the determination of cost-effectiveness on a life-cycle cost analysis of the project. Under the terms of the bill, the determination of cost-effectiveness would be made on the basis of an economic analysis, including a life-cycle cost analysis.

After reviewing several of the economic analyses prepared by private consultants, the committee decided to expand the criterion to an overall economic analysis, of which the life-cycle cost analysis is an integral part. The life-cycle costs for each of the alternatives considered represent the present value of the stream of costs to be incurred each year during the life cycle of the alternatives being considered. These costs include the initial capital cost and recurring annual operating costs, personnel costs, transition costs of moving in and occupying the new facility, and CHAMPUS costs in the catchment area of the facility. These costs will vary both in magnitude and timing depending on size of the facility.

By contrast, in determining the effectiveness of the various alternatives, current analyses weigh such additional factors as the operations-related benefits associated with the efficient operation of the military health care delivery system and health planning criteria-related benefits associated with Public Law 93-641, the National Health Planning and Resources Development Act of 1974. The latter portion of the analysis, for example, would ensure that health planners have fully reviewed and considered the interaction of the proposal facility with other hospitals in the area, both Federal and non-Federal. Such considerations should be included as part of the proposed economic analysis.

The committee intends that the Secretary of Defense, in consultation with the service Secretaries, exercise flexibility in determining the appropriate degree of economic analysis required, based upon the size, cost, and complexity of the facility involved.

MOBILIZATION CAPABILITY

An additional and very important benefit will accrue from more flexible sizing criteria for military hospitals: enhanced mobilization capability. During peacetime, the resources of the military health care delivery system are devoted to meeting the medical needs of the current beneficiary population, active duty personnel, dependents, retirees, and survivors. The military medical care system exists for another, more critical reason: provision of wartime care.

The military services must have the capability to treat combat casualties in the battle theater, in interim staging facilities overseas, and in medical facilities within the United States. Military medical planners have long despaired that the downsizing of medical facilities that often results from current policy could bear bitter fruit in the event of substantial wartime casualties. Military hospitals may be unable to respond to the requirement for rapid expan-

sion in the number of beds necessary to receive the wounded in any appreciable numbers.

The Department of Defense has testified that the enactment of this legislation would contribute further to ongoing efforts to improve the direct care system's mobilization capabilities by slowing the rate of loss of beds in Department of Defense hospitals. The Acting Assistant Secretary of Defense for Health Affairs has testified that, unless current law and policy are changed, the military departments will lose approximately 20 percent of the hospitals beds currently existing in the direct care system over the next twenty years.

The impact of this trend on mobilization is obvious.

MILITARY HOSPITALS AT THE THREE MILITARY ACADEMIES

Problems with the current sizing criteria are highlighted when focus is placed on specific examples.

Currently, only two of the three military academies have a hospital. In 1979, as a result of a shore establishment realignment study, the aging hospital at the U.S. Naval Academy was downgraded to an outpatient clinic. Midshipmen requiring hospitalization must travel considerable distances to the Naval Regional Medical Center in Bethesda or to Kimbrough Army Hospital at Fort Meade, Maryland. In veiw of the distance to these military facilities, emergency cases must normally be taken to Anne Arundel Community Hospital.

Under the current sizing criteria, Navy health care planners assert that the construction of a replacement hospital at the Naval Academy, though desirable from the perspective of instilling institutional norms in the midshipmen, would not be cost-effective. The additional flexibility that this bill would provide would enable the Navy to consider the current cost of CHAMPUS care for the large retiree population in the Annapolis area and, thereby, construct a slightly larger, more cost-effective facility.

The bill would require, subject to the availability of appropriations, that there be a hospital at each of the three military academies and that additional space for retirees be programmed in accordance with the expanded criteria envisioned in the legislation. This will have a favorable impact on the midshipmen and result in the cost-effective provision of medical care in that area.

USE OF REALISTIC INFLATION PROJECTIONS

The long-term economies envisioned in this legislation will not materialize unless realistic rates of inflation in the medical sector of the economy are used in preparing life-cycle cost estimates as a part of the economic analyses. Specifically, the factors used to project costs of providing military medical care or CHAMPUS cost should be based on actual experience in recent years with respect to the costs of hospital care, physician services, prescriptions, supplies, and other reimbursable expenses. It would be counterproductive to the purpose of this legislation to use a lower cost projection than estimates based on historical experience would dictate solely because budget planners hope, without substantiating evidence, for a decline in medical costs at some point in the future.

As a case in point, the committee has recently considered a request by the Department of Defense to reprogram $100 million from other operation and maintenance accounts into CHAMPUS to offset the shortfall for the remainder of fiscal year 1982. Although part of the shortfall is due to a greater rate of CHAMPUS usage than originally projected, the major portion of the shortfall, according to testimony presented by Defense officials, results from a medical inflation rate substantially greater than anticipated in the budget submission. The fiscal year 1982 budget submission assumed an eight percent inflation increase: Actual experience for hospital costs has been a 20 percent rate of increase instead. Physician services have increased by 11 percent; prescriptions, equipment, supplies, and other ancillary services, by 12.4 percent. Thus, $69.4 million of the $100 million shortfall is based on unanticipated medical cost growth alone. If the budget submission had been based on a more realistic cost growth factor, based on extrapolations of the actual experience of the past five years, for example, much of this shortfall would not have occurred.

The committee's intent in approving this legislation is to reduce expenditures in the years ahead by ensuring that medical care for military beneficiaries is provided in the most cost-effective manner. This process will be frustrated if the regulations prescribing procedures for the economic analysis do not require the use of realistic inflation factors. The committee, therefore, directs the Secretary of Defense, in issuing regulations implementing the provisions of this legislation, to ensure that such regulations require the use of realistic inflation factors, based on historical data within the medical sector of the economy, in the preparation of life-cycle cost comparisons and economic analyses.

Departmental Data

The need for legislation such as is embodied in H.R. 3278 was discussed during a hearing conducted jointly by the Subcommittee on Military Personnel and Compensation and the Subcommittee on Military Installations and facilities. The testimony provided by representatives of the Department of Defense was generally supportive of the provisions contained in the bill.

The following delineates the Defense Department's analysis of the impact of the legislation in the near term:

Assistant Secretary of Defense,
Washington, D.C., September 20, 1982.

Hon. William Nichols,
Chairman, Subcommittee on Military Personnel and Compensation, Committee on Armed Services, House of Representatives, Washington, D.C.

Dear Mr. Chairman: In reply to your staff's request for an estimate by the Office of the Assistant Secretary Defense (Health Affairs) as to the cost impact of amending legislation pertaining to

sizing DoD medical facilities for retirees and their dependents—Section 1087, title 10, U.S.C., the enclosed information is forwarded.

Sincerely,

VERNON MCKENZIE,
Deputy Assistant Secretary of Defense.

FINDINGS OF ECONOMIC ANALYSES PERFORMED FOR MAJOR HOSPITAL CONSTRUCTION PROJECTS PROPOSED FOR FISCAL YEAR 1982 To FISCAL YEAR 1986

[Dollars in millions]

	Fiscal year 1985, Travis	Fiscal year 1983, Carswell	Fiscal year 1982, Carson	Fiscal year 1982, Wright-Patterson	Fiscal year 1986, Madigan
Current number of beds operated	290	115	140	285	409
Existing law:					
Beds	[1]204	77	155	234	[1]301
Capital costs	$166	$42	$77	$106	$253
Annual operating costs	$874	$503	$374	$395	$731
Transition costs	$1	$0.9	$0.6	$0.8	$1.6
Total lifecycle costs to the Government	$1,041	$546	$451	$502	$986
Lifecycle analysis:					
Beds	290	168	195	332	477
Capital costs	$202	$66	$105	$115	$388
Annual operating costs	$626	$451	$331	$383	$646
Transition costs	$2	$1	$0.7	$1.3	$2.1
Total lifecycle costs to the Government	$830	$518	$436	$499	$1,046
Total lifecycle benefit to the Government	$211	$28	$14	$3	($60)

[1] Subsequent to the findings of these reports, the department accepted evidence that the exception provision of section 1087 pertaining to large concentrations of retirees for which a critical shortage of beds is projected was applicable to the Travis and Madigan projects. As a result, Travis was authorized to be designed for 295 beds and Madigan was authorized to be designed for 378 beds.

SECTION-BY-SECTION ANALYSIS

Section 1 of the bill would modify the existing criteria for determining the amount of space that may be programmed for retirees and their dependents in uniformed services medical and dental facilities. These criteria are found in section 1087 of title 10, United States Code. Section 1 of the bill would designate the existing language in section 1087 of title 10 as subsection (a) and replace the existing limitations with the new criteria.

Under the new criteria, the amount of space above that required for active duty personnel and their dependents that may be programmed for a facility would be limited to the greater of two calculations. The first determination, specified in clause (1) of the new subsection (a), would be based on the additional amount of space that would be required to support teaching and training of health-care professionals. The second determination, specified in clause (2) of the new subsection (a), would be based on the additional amount of space required to provide the most cost-effective inpatient and outpatient care for retirees and their dependents. Uniformed services facilities could be constructed or modified to include space up to the largest additional amount determined in clause (1) or (2).

Section 1 of the bill would also add a new subsection (b) to section 1087 of title 10. The new subsection would require in para-

BEST DOCUMENT AVAILABLE

graph (1) that consideration be given in the determination made in subsection (a) to the projected inpatient and outpatient workloads for retirees and their dependents. In addition, paragraph (1) would require that consideration be given in the determination made in subsection (a) to the staffing resources that are expected to be available to the facility. The staffing resources should be determined in accordance with regulations prescribed by the Secretary of Defense and should be based on realistic projections of the number of physicians and other health-care providers that can reasonably be expected to be assigned to or be available to the facility. It is intended that the regulations governing projections of staffing capabilities and the actual projections of health-care providers be developed through coordination with the individual service Secretaries.

The new subsection (b) would also require in paragraph (2) that the determination of the amount of space required to provide the most cost-effective care for retirees and their dependents under clause (2) of subsection (a) be made in accordance with an economic analysis (including a life-cycle cost analysis) of the facility. Consideration should also include all reasonable and available medical care treatment alternatives (including treatment under CHAMPUS and under Medicare).

Section 1 of the bill would also add a new subsection (c) to section 1087. The new subsection (c) requires that any hospital at the United States Military Academy, the United States Naval Academy or the United States Air Force Academy have additional space programmed for retirees and their dependents in accordance with the new subsection (a).

Section 2 of the bill would add a new section 1091 to the end of chapter 55 of title 10, United States Code. The section 1091 would require, subject to the availability of appropriations, a hospital at the United States Military Academy, the United States Naval Academy and the United States Air Force Academy.

Section 3 of the bill would restrict application of the amended section 1087 (related to the determination of additional space in military medical facilities for care for retirees and their dependents) to facilities for which funds for construction (or major alteration) are first appropriated for a fiscal year after fiscal year 1983.

Committee Position

The Committee on Armed Services on September 21, 1982, a quorum being present, approved H.R. 3278, with amendment, by voice vote.

Fiscal Data

Pursuant to the House rules, the five-year cost projection of the legislation as estimated by the Department of Defense, the Congressional Budget Office, and the Committee on Armed Services follow.

DEPARTMENTAL COST ESTIMATE

The Department of Defense was unable to provide an estimate of the outlays resulting from the provisions contained in H.R. 3278 for fiscal year 1983 and the four following fiscal year. As outlined under the Departmental Data section printed earlier in the report, the Defense Department did submit an analysis of the impact that the legislation could have on five hospital construction projects over the next five years.

The Department of Defense indicates that projects in the fiscal year 1983 to 1985 military construction program are sized in accordance with existing law. Therefore, the department states that this legislation, if enacted, would have no appreciable impact on these program years.

Projects in the fiscal year 1986 and 1987 time frame may be increased in scope as a result of the enactment of H.R. 3278. Due to budgetary constraints, the department states that any increase in project costs would be absorbed by deferring constructing of other projects into subsequent years.

With respect to the effect on CHAMPUS costs, the department projects that cost savings in CHAMPUS would occur no sooner than fiscal year 1989; however, defense estimates that these savings would ultimately fully offset additional near term capital expenditures.

The legislation envisions that economic analyses would be prepared on new or replacement military medical facilities. Because such analyses have been required by Congressional committee reports and DOD instructions since 1978, however, the department states that no new costs would be attributable to the performance of the studies.

Congressional Budget Office Cost Estimate

In compliance with clause 2(l)(3)(C), Rule XI of the Rules of the House of Representatives, the estimate prepared by the Congressional Budget Office and submitted pursuant to section 403 of the Congressional Budget Act of 1974 is included hereafter.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE, SEPTEMBER 22, 1982

1. Bill number: H.R. 3278.

2. Bill title: To provide additional standards for determining the amount of space to be programmed for military retirees and their dependents in medical facilities of the uniformed services, and for other purposes.

3. Bill status: As ordered reported by the House Armed Services Committee on September 21, 1982.

4. Bill purpose: H.R. 3278 revises the manager in which DOD determines allowable hospital space, including the preparation of studies to determine space needs, and allows for a military hospital at each of the three Service academies.

5. Cost estimate:

[By fiscal year, in millions of dollars]

Function 050	1983	1984	1985	1986	1987
Estimated authorization				25.2	0.1
Estimated outlays				4.4	10.1

6. Basis of estimate: Authorizations are estimated as indicated below. All estimated authorizations are assumed to be appropriated before each fiscal year.

The bill requires that for all uniformed services hospital facility construction for which funds are appropriated after fiscal year 1983, the capacity is to be determined by the greater of the space required: (a) to support teaching and training requirements; or (b) to provide the most cost-effective inpatient and outpatient care to retired members or their dependents who are eligible for such care. An economic analysis that includes life-cycle costing is required in order to determine cost-effectiveness. Facility inpatient and outpatient workload, based on the needs of eligible retired members and their dependents, as well as medical and dental staff availability are to be considered in making the determination of space to be programmed.

Studies required under this legislation vary in cost from $100,000 to no cost. Each economic analysis is estimated by DOD to cost $100,000 when done by a contractor. There is no new cost to studies done inhouse by DOD personnel, because such work will be done with existing personnel and other resources. Three economic analysis may be done within the next five years. No determination has been made concerning who will do the work. If done by outside contractors, the estimated cost would be $300,000. Teaching and training space studies are already done under current law. Workload studies will add no cost because DOD already gathers the required data for other uses, such as war time hospital capacity studies. Staff availability studies are carried out as part of DOD's regular budget development process to determine manpower requirements and meet end-strength limitations.

The bill also contains a provision that requires that a hospital facility be constructed at each service academy, if funds are available. Only the Naval Academy does not already have a hospital. DOD estimates that a Naval Academy hospital would require a total of $25 million for construction. This amount would be requested in the fiscal year 1986 budget. Because the bill applies only to facilities for which funds for construction are first appropriated after fiscal year 1983, none of the facilities now programmed by DOD will be affected by this bill. Each of the two facilities presently programmed by DOD for after 1983 is already exempt from space limitations as a result of provisions in existing law, therefore no new costs will occur as a result of this provision. Because DOD cannot request construction funds for hospital facilities without 35 percent of the design work being completed, an approximately 18 month process, DOD does not anticipate any further hospital facility construction requests between 1983 and 1987.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

BEST DOCUMENT AVAILABLE

COMMITTEE COST ESTIMATE

Pursuant to clause 7, Rule XIII of the Rules of the House of Representatives, the committee attempted to determine outlays resulting from the bill for fiscal year 1983 and the four following fiscal years.

The committee generally concurs with the estimate of the Congressional Budget Office. However, the committee notes that the added incremental cost $14.5 million over the next 5 years would be subject to the Congressional authorization and appropriations process. Thus, Congress would in all probability offset the slight added expenditure by eliminating or deferring other projects of lesser priority.

INFLATION-IMPACT STATEMENT

Pursuant to clause 2(l)(4) of rule XI of the Rules of the House of Representatives, the committee examined the possible inflationary impact of the bill. It is the belief of the committee that the enactment of this legislation will not have an inflationary impact on the economy of the United States.

OVERSIGHT FINDINGS

With reference to clause 2(l)(3)(D) of rule XI of the Rules of the House of Representatives, the committee has not received a report from the Committee on Government Operations in regard to this matter.

With reference to clause 2(b)(1) of rule X of the Rules of the House of Representatives, the committee finds and recommends that the legislation be enacted pursuant to its oversight responsibilities.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of Rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

TITLE 10, UNITED STATES CODE

* * * * * * *

Subtitle A—General Military Law

* * * * * * *

PART II—PERSONNEL

* * * * * * *

CHAPTER 55—MEDICAL AND DENTAL CARE

Sec.

1071. Purpose of sections 1071-1087 of this title.

* * * * * * *

1091. Hospitals at service academies.

* * * * * * *

§ 1087. Programing facilities for certain members, former members, and their dependents in construction projects of the uniformed services

(a) Space for inpatient and outpatient care may be programed in facilities of the uniformed services for persons covered by sections 1074(b) and 1076(b) of this title. [The amount of space so programed shall be limited to that amount determined by the Secretary concerned to be necessary to support teaching and training requirements in uniformed services facilities, except that space may be programed in areas having a large concentration of retired members and their dependents where there is also a projected critical shortage of community facilities.] *The maximum amount of space that may be so programed for a facility is the greater of—*

(1) the amount of space that would be so programed for the facility in order to meet the requirements to be placed on the facility for support of the teaching and training of health-care professionals; and

(2) the amount of space that would be so programed for the facility based upon the most cost-effective provision of inpatient and outpatient care to persons covered by section 1074(b) and 1076(b) of this title.

(b)(1) In making determinations for the purposes of clauses (1) and (2) of subsection (a), the Secretary concerned shall take into consideration—

(A) the amount of space that would be so programed for the facility based upon projected inpatient and outpatient workloads at the facility for persons covered by section 1074(b) and 1076(b) of this title; and

(B) the anticipated capability of the medical and dental staff of the facility, determined in accordance with regulations prescribed by the Secretary of Defense and based upon realistic projections of the number of physicians and other health-care providers that it can reasonably be expected will be assigned to or will otherwise be available to the facility.

(2) In addition, a determination made for the purpose of clause (2) of subsection (a) shall be made in accordance with an economic analysis (including a life-cycle cost analysis) of the facility and consideration of all reasonable and available medical care treatment alternatives (including treatment provided under a contract under section 1086 of this title or under part A of title XVIII of the Social Security Act).

(c) The hospitals at the United States Military Academy, the United States Naval Academy, and the United States Air Force Academy shall have space for inpatient and outpatient care for persons covered by section 1074(b) and 1076(b) of this title. The amount of such space shall be programed in accordance with subsection (a).

* * * * * * *

§ 1091. Hospitals at service academies

Subject to the availability of appropriations, there shall be a hospital at the United States Military Academy, the United States Naval Academy, and the United States Air Force Academy.

* * * * * * *

Bill Summary

PURPOSE

The purpose of H.R. 3278 is twofold. First, the bill would provide additional criteria that may be used in determining the amount of space to be programmed for military retirees and their dependents in military medical facilities. In addition to the current statute permitting an incremental increase based on teaching and training requirements, the bill would permit space to be programmed based on the most cost-effective method of heath care delivery to the beneficiaries served by that facility, as determined by an economic analysis that includes a life-cycle cost comparison of sizing alternatives. The ultimate sizing decision would, additionally, be based upon the workload and the projected availability of medical staff for the facility.

Second, it would state that, subject to the availability of appropriations, there should be a hospital at each of the three military academies.

FISCAL DATA

The Congressional Budget Office five-year cost estimate projects increased outlays of $4.4 million in fiscal year 1986 and $10.1 million in fiscal year 1987.

The committee generally concurs in the estimate of the Congressional Budget Office, however, the committee notes that the slight increase in cost is expected to be offset by the deferral of items of lesser priority into later year budgets.

DEPARTMENTAL DATA

The Department of Defense has testified favorably on provisions generally similar to those contained in the bill.

COMMITTEE POSITION

The Committee on Armed Services on September 21, 1982, a quorum being present approved H.R. 3278, with amendment, by voice vote.

○